

## HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

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The following describe the different ways in which we may use and disclose your medical information.

1. **Treatment:** in order to treat you and may disclose information to others who assist you with your care or treatment.
2. **Payment:** in order to bill and collect payment for services you receive from us. We may use and disclose information to obtain payment from third parties that may be responsible for such costs such as family members. We may use your medical information in order to bill you directly for services and items.
3. **Health Care Operations:** to operate our Business to ensure you receive quality care and to Assure our practice is well run.
4. **Appointment Reminders:** to remind you that you have an appointment at the daytime number you provide us with.
5. **Treatment Alternatives:** to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.
6. **Fundraising:** in order to contact you as part of Fundraising activity. We may disclose your information to a business associate or to a foundation related to our organization to raise money for our organization. Name and address only will be used.
7. **Marketing:** to make a marketing communication to you that occurs in a fact-to-face encounter with you; concerns products or services of nominal value; or concerns our health-related products or services, or those of another party, provided that we tell you that we are the party communicating with you, and tell you if we have received, or will receive, directly or indirectly, any money or other remuneration for making the communication to you.

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8. **Required By Law:** when required by applicable law regarding crime or criminal conduct, warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release of records signed by you or verbal authorization obtained from you or your attorney of record or proof of service from the requesting party) we must honor the request.

9. **Public Health Activities:** to control disease, injury, or disability; maintain vital records such as birth or death; report child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalled devices or medications. To notify appropriate government agencies and authorities regarding the potential abuse or neglect Of an adult patient including domestic abuse if the patient agrees or we are required or authorized by law to do so. Under limited circumstances, to your employer for related workplace injury or illness or medical surveillance.

10. **Coroners, Medical Examiners, and Funeral Directors:** as needed to carry out their duties required by law.

11. **Organ and Tissue Donation:** to organizations that handle organ and tissue procurement, banking or transplantation.

12. **Research:** subject to special approval process, information may be used on research projects or studies. The information will not leave our premises.

13. **Serious Threats to Health Or Safety:** to reduce or prevent a serious threat to your health and safety or that of another individual or the public. We will only disclose to persons or organizations able to help prevent the threat.

14. **Specialized Government Functions:** if you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.

15. **Workers Compensation:** our organization will release your medical information for workers' compensation and similar programs to all parties as required by state and federal law.

## YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

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You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction in our use or disclosure of your medical information, you must make your request in writing to the address on the back of this brochure.

\* **Requesting Restrictions:** the right to request a restriction in our use or disclosure of your medical information for treatment, payment or health care operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends.

\* **Confidential Communications:** the right to request our organization to communicate with you about your health and related issues in a particular manner or certain locations without stating a reason for your request.

\* **Inspections and Copies:** the right to inspect and obtain copies of the medical information that may be Used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address on the back of the brochure.

# HIPAA

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\* **Amendment:** the right to ask us to amend your medical information if you believe it is incorrect or incomplete, and you may request an amendment for as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason for your request in writing to the address in the back of this brochure. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information kept by or for our practice; not part of the information which you are permitted to inspect and copy; not created by our practice, unless the individual or entity that created the information is not available to amend the information.

\* **Accounting of Disclosures:** the right to request an accounting of disclosures made of your medical information entities that you do not have an established relationship with. In order to obtain an accounting, you must submit your request in writing to the address on the back of this brochure. All requests may not be longer than 6 years and may not include dates prior to October 16, 2002. The first request in a 12-month Period is free of charge. You will be charged for any Additional lists requested in a 12-month period.

\* **Right to File a Complaint:** If you believe your rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing to the address on the back of this brochure.

\* **Rights to Provide an Authorization of Other uses and Disclosures:** our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

\* **Right to a Paper Copy of This Notice:** you are entitled to receive a paper copy of this notice of privacy practices. You will be asked to sign an acknowledgment proving receipt of this Notice of Privacy Practices.

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